



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.healthplus.org](http://www.healthplus.org) or by calling 1-800-332-9161.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$125/person \$250/family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	There are no other specific <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$2,000/person \$4,000/family	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See <a href="http://www.healthplus.org">www.healthplus.org</a> or call 1-800-332-9161 for a list of participating providers.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	Yes.	This plan will pay some or all of the costs to see a <u>specialist</u> for covered services, but only if you have the plan's permission before you see the <u>specialist</u> .
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <u>excluded services</u> .

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- **Copayments** are fixed dollar amounts (for example, \$20) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 copayment	Not covered	General or Family Practitioners, Internists, and Pediatricians are considered Primary Care Physicians.
	Specialist visit	\$20 copayment	Not covered	Referral required.
	Other practitioner office visit	\$20 copayment; Allergy services: \$0 copayment	Not covered	Deductible applies to allergy testing only.
	Preventive care/screening/immunization	\$0 copayment	Not covered	Prior Authorization is required on certain out-of-network preventive services.
If you have a test	Diagnostic test (x-ray, blood work)	\$0 copayment	Not covered	Deductible applies.
	Imaging (CT/PET scans, MRIs)	\$0 copayment	Not covered	Prior Authorization is required. Deductible applies.
If you need drugs to treat your illness or condition More information about <u>prescription drug</u>	Generic drugs	\$10 copayment	Not covered	<ul style="list-style-type: none"> <li>• \$0 copay for select generic maintenance/preventive drugs.</li> <li>• Up to 90 day supply is available by mail order or retail for 2 copays.</li> <li>• Some drugs require prior</li> </ul>
	Preferred brand drugs	\$30 copayment	Not covered	
	Non-preferred brand drugs	\$60 copayment	Not covered	

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Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<u>coverage</u> is available at <a href="http://www.healthplus.org">www.healthplus.org</a> .	Specialty drugs	\$60 copayment	Not covered	authorization and/or mandatory 90 day supply. • Call HealthPlus at 1-800-332-9161 or visit the pharmacy center website for a list of specialty drug pharmacies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$0 copayment	Not covered	Some services require Prior Authorization. Deductible applies.
	Physician/surgeon fees	\$0 copayment	Not covered	————None————
If you need immediate medical attention	Emergency room services	\$200 copayment	\$200 copayment	Copayment waived if admitted.
	Emergency medical transportation	\$0 copayment	\$0 copayment	Deductible applies.
	Urgent care	\$20 copayment	\$20 copayment	————None————
If you have a hospital stay	Facility fee (e.g., hospital room)	\$0 copayment	Not covered	Some services require Prior Authorization. Deductible applies.
	Physician/surgeon fee	\$0 copayment	Not covered	————None————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20 copayment	Not covered	Some services require Prior Authorization. Deductible applies to inpatient services.
	Mental/Behavioral health inpatient services	\$0 copayment	Not covered	
	Substance use disorder outpatient services	\$20 copayment	Not covered	
	Substance use disorder inpatient services	\$0 copayment	Not covered	
If you are pregnant	Prenatal and postnatal care	Prenatal: \$0 copayment Postnatal: \$20 copayment	Not covered	Prior Authorization required for out-of-network services. Deductible applies to delivery and all inpatient services.
	Delivery and all inpatient services	\$0 copayment	Not covered	

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Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<b>If you need help recovering or have other special health needs</b>	Home health care	\$20 copayment	Not covered	Deductible applies.
	Rehabilitation services	\$20 copayment	Not covered	Physical, speech and occupational therapy limited to 90 combined visits per year.
	Habilitation services (autism only)	\$0 copay	Not covered	Coverage for Autism Spectrum Disorder only, all other habilitation services not covered. Prior authorization required. Coverage through age 19 (date of birth). Deductible applies.
	Skilled nursing care	\$0 copayment	Not covered	Deductible applies. Limited to 120 days per year.
	Durable medical equipment	\$0 copayment	Not covered	Prior authorization required for items \$1,500 and over and selected items under \$1,500.
	Hospice service	\$0 copayment	Not covered	Deductible applies.
<b>If your child needs dental or eye care</b>	Eye exam	Not covered	Not covered	—————None—————
	Glasses	Not covered	Not covered	
	Dental check-up	Not covered	Not covered	

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<ul style="list-style-type: none"><li>Acupuncture (if prescribed for rehabilitation purposes)</li><li>Cosmetic surgery</li><li>Dental care (Adult)</li></ul>	<ul style="list-style-type: none"><li>Infertility treatment</li><li>Long-term care</li><li>Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>Private-duty nursing</li><li>Routine eye care (Adult)</li><li>Routine foot care</li><li>Weight loss programs</li></ul>
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"><li>Bariatric surgery (if Medically Necessary)</li><li>Chiropractic care (referral required)</li></ul>	<ul style="list-style-type: none"><li>Emergency care when traveling outside the U.S.</li><li>Hearing aids</li></ul>	<ul style="list-style-type: none"><li>Infertility treatment (limited to artificial insemination)</li><li>Podiatry services (referral required)</li></ul>

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-332-9161. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeal Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: HealthPlus of Michigan at 1-800-332-9161, by mail at 2050 S. Linden Road, P.O. Box 1700, Flint, Michigan, 48501-1700 or by fax at 1-810-733-1947.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **Coverage under this plan qualifies as minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-332-9161.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-332-9161.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-332-9161.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 1-800-332-9161.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** \$7,540
- **Plan pays** \$7,245
- **Patient pays** \$295

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$125
Copays	\$20
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$295</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$4,595
- **Patient pays** \$380

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$200
Vaccines, other preventive	\$200
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$125
Copays	\$600
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$805</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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